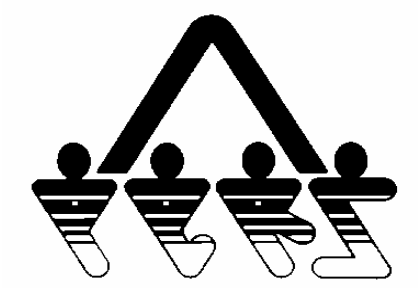
North Dakota Public Employees Retirement System



FlexComp Program

Effective January 1, 2005

NDPERS
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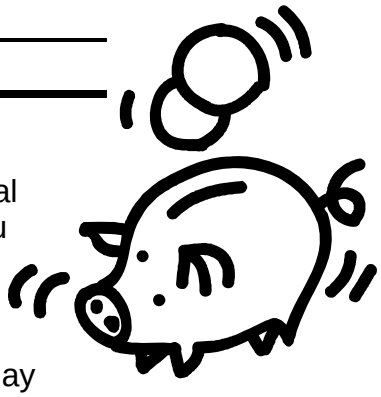
Rev. 01/05

ELIGIBILITY

The FlexComp Plan is available to eligible employees of the State of North Dakota and participating District Health Units. Members of the Legislative Assembly are also eligible to participate. Employees of the university system and political subdivisions are excluded from participation in the plan. To be eligible, an employee must be 18 years of age, work at least 20 hours per week for at least 20 weeks per year and be in a regularly funded position not of limited duration.

"FLEXCOMP PLAN"



A "FlexComp Plan" is another term for a Cafeteria Plan and is established and administered under Section 125 of the Internal Revenue Code. It allows you to save taxes on the amount you pay for eligible insurance premiums, medical expenses and dependent care expenses. Since the dollars you contribute to the plan are deducted before income and social security taxes are deducted, you will pay less tax, which means you may have more money to spend or save. However, you should be aware you are reducing the social security taxes paid, which could slightly reduce your social security benefits.

In exchange for the significant tax breaks you receive, the IRS imposes strict regulations on the use of flexible spending accounts. It's important to carefully estimate the amounts you contribute. Please review "Important IRS Rules" in this booklet.

ENROLLMENT

The Plan Year is January 1 through December 31. The annual enrollment is from October 1 through November 15. New employees who meet eligibility requirements must enroll within 60 days of their hire date. You may also enroll or change your election during the Plan year if you experience an IRS Qualified Change of Status and your enrollment or election change is consistent with, and on account of, the status change. You will have 60 days from the change in status event to enroll or change your election.

Participants may begin to incur eligible expenses on the effective date of their participation. New employees and employees who are enrolling because of a qualifying change in status will become a participant the month the first contribution is received. For employees enrolling during open enrollment, participation in the Plan will begin January 1.

The final day for accepting claims for the Plan Year for services received while you were a participant is three months after the Plan Year ends on December 31, or until March 31.

FLEXCOMP BENEFITS

Employees may elect to participate in any combination of the three pre-tax accounts.

Premium Conversion
Allows you to pay, with pretax dollars, certain premiums under various insurance programs available for payroll deduction through your employer.

Examples of eligible insurance premiums available through payroll deduction:
• Cancer insurance
• Dental insurance
• Vision insurance

We will automatically pre-tax your premium deduction for the first $50,000 of ING employee supplemental life insurance coverage unless you make an election to decline this action in Section B of the FlexComp enrollment form. Please note, if you pretax your insurance premium, you may not change or drop coverage during the plan year unless you experience an IRS Qualified Change of Status.

Medical Spending Reimbursement Account
An employee may redirect a portion of their salary for eligible medical expenses up to a plan year maximum of $6,000. Requests for reimbursement from your Medical Spending Account will be paid throughout the year according to your total annual medical spending election amount.

Eligible Medical Expenses (See Eligible Expenses for a more detailed listing)
Examples of eligible medical expenses include:

- Insurance co-payments, coinsurance and deductibles.
- Prescription co-payments and coinsurance.
- Optometry expenses not covered by insurance, including examinations, contact lenses, contact solutions, prescription eyeglasses, prescription sunglasses, and laser surgery to correct vision.
- Dental and orthodontia expenses not covered by insurance, including fillings, x-rays, exams, cleaning, extractions, dentures, braces.
- Medicines not requiring a prescription purchased Over-the-Counter.

Special Rules for Orthodontic Treatment
Requests for reimbursement of orthodontic expenses may be reimbursed on a monthly payment schedule as payment is required and paid. You

must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. To be reimbursed for orthodontic expenses that will be incurred during a plan year, a copy of the contract or statement from the provider must be submitted, along with a receipt showing date and amount of payment.

Ineligible Expenses

You cannot obtain reimbursement for:

- Costs incurred before coverage is effective or after coverage ends.
- Insurance premiums.
- Cosmetic procedures; e.g. facelifts, skin peeling, teeth whitening, removal of spider veins, breast reduction, unless a physician substantiates the procedure is medically necessary and not for cosmetic purposes.
- Contact lens insurance and maintenance agreements, an eyeglass warranty, clip-on sunglasses.
- Exercise equipment, health club dues, personal trainers used to improve appearance or for general health.
- Massage therapy unless prescribed by a physician to treat a specific medical condition (see Eligible Expenses).
- The full cost of a chiropractic maintenance agreement.
- Marriage counseling services.
- Illegal operations or treatments.
- Travel your doctor told you to take for a rest or change.

Dependent Care Reimbursement Account

An employee may redirect a portion of their salary up to a maximum limit of $5,000 for a single parent, $5,000 for a married couple filing a joint tax return or $2,500 for a married person filing a separate tax return. Requests for reimbursement from a Dependent Care Reimbursement Account will be paid according to the dollars available in your account to date.

Eligible Dependent Care Expenses

Day care expenses must:

- Be for the purpose of enabling you or you and your spouse to be employed.
- Be for a child under 13 years of age who is your dependent under Federal tax rules. The child must reside with the employee at least one-half of the taxable year.
- The dependent care account can also be used for the care of a spouse or a dependent over the age of 13 who is incapable of self-care. The adult dependent who is incapable of self care must live with the employee for more than one-half the taxable year and not have more then $3,200 per year in gross income.

Ineligible Expenses

You cannot obtain reimbursement for:

- Food, transportation, registration, or supply fees if they are billed separately from the dependent care expenses.
- Kindergarten expenses that are primarily educational in nature, regardless of half or full day, private or public school, state mandated or voluntary. However, if your day care provides kindergarten that is run on the order of a nursery school, with the child's education merely incidental to the care provided and the cost cannot be separated from the cost of the child care, the entire amount can be considered an eligible expense.
- Expenses paid to someone you or your spouse can receive a personal tax exemption for as a dependent.

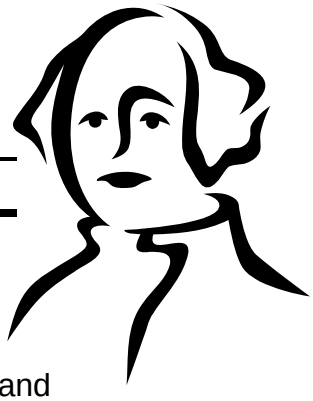
Dependent Care Reimbursement Account vs. Dependent Care Tax Credit

The Dependent Care Reimbursement Account is an alternative to taking a dependent care tax credit on your income tax return. You must choose whether to take the tax credit or enroll in the Dependent Care Reimbursement Account. The IRS will not allow you to receive two tax breaks on the same expenses.

The income level of you or if married, you and your spouse, will determine whether the Dependent Care Reimbursement Account or the income tax credit is more favorable for you. Contact a qualified tax consultant for complete details.

Payments made to you from a dependent care account are not taxable, but the amount redirected will appear on your W-2 form. This will inform the IRS that you have received a tax break on that expense through the FlexComp Plan. You are required to file Schedule 2 with your IRS Form 1040A or Form 2441 with your IRS Form 1040 to support the amount redirected for the plan year.

Please note that this is for general information only and is not intended to provide specific advice or recommendations. We suggest you consult your accountant or tax advisor with regard to your individual situation.



IMPORTANT IRS RULES

There are three important points that you should consider when participating in the FlexComp Program:

- Use It or Lose It – The FlexComp plan year begins January 1 and ends December 31. The IRS requires that any money left in your account(s) at the end of the year be forfeited. Therefore, you must incur enough expenses during the plan year to use the balance of your account. You'll have three months after the end of the plan year on December 31, or until March 31 to file claims for expenses incurred during the plan year. NDPERS will keep you informed about your account balances by providing you with quarterly statements throughout the plan year to let you know how much money you have used and what you have left in your account(s).

- Separate Accounts – You may participate in either or both flexible spending accounts. Because the Medical Spending Account and Dependent Care Spending Account are separate accounts, you may not use money from one account to cover expenses in the other.

- Change in Participation – The IRS requires that once you elect to participate, your payroll deductions may not be stopped or changed until the start of the next plan year. The only exception is if you experience an IRS Qualified Change of Status.

IRS QUALIFIED CHANGE IN STATUS EVENTS

In most circumstances, your annual election amounts or any insurance premiums you are having payroll deducted pre-tax cannot be changed. You may change your election if you have a gain or loss of eligibility for coverage under this Plan or a plan maintained by your spouse's employer or your dependent's employer that is caused by a qualifying change in status and your election change corresponds with the gain or loss of coverage. You may be able to make a change under the following circumstances:

1. If you go on a leave of absence, military leave, or a leave covered by the Family and Medical Leave Act (FMLA), your medical spending and dependent care contributions and pre-tax insurance premiums may be made as follows:

    - Under the pre-pay option, you may pay the amounts due while on leave in a lump sum on an after-tax basis. Contributions under the pre-pay option may also be made on a pre-tax basis by having the total contribution due, while on leave, payroll deducted prior to your leave.

    - Under the pay-as-you-go option, you may make after-tax contributions by submitting payments to NDPERS by the first of each month while on leave. Contributions may also be made pre-tax from any taxable compensation, such as annual leave or sick leave during the leave period.

    - You may elect not to participate in the Plan while on leave. If you elect not to participate while you are on a leave of absence, you will not be entitled to receive reimbursements for claims incurred beyond the last day of the month a contribution is received. Upon returning from leave, you may reinstate your coverage that was in effect prior to your leave or reinstate the coverage less the contributions that were missed during the leave.

2. Your legal marital status changes through marriage, divorce, death, legal separation or annulment.

3. Your number of dependents changes because of birth, adoption (or placement for adoption), or death.

4. There is a change in your employment status or the employment status of your spouse or any dependents. The employment status change must affect eligibility under this Plan or a plan maintained by the employer of your spouse or dependent due to termination of employment or a change from full-time to part-time or part-time to full-time employment. If you change employment status from full-time to part-time or part-time to full-time, your election change must correspond with the gain or loss of coverage. If your spouse or dependents have an employment status change that affects eligibility under their employer's plan, and coverage is lost, then you may increase coverage under this Plan. If the status change results in your spouse or dependents gaining coverage under their employer's plan, you may decrease coverage under this Plan.

5. One of your dependents satisfies or ceases to satisfy the requirement for coverage under the Health Insurance Plan. For unmarried dependents due to attainment of age, a change in student status, or marital status would allow you to make a corresponding change to increase or decrease coverage under this Plan for the dependent.

6. If you are served with a judgment, decree or court order. This includes divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for your child. It would allow you to make an election change to your Medical Spending Account. The change is allowed in order to provide coverage for the child if the order requires coverage under your Plan; or cancel coverage for the child if the order requires your former spouse to provide coverage.

7. You, your spouse, or any of your dependents become eligible or lose eligibility for coverage under Medicare or Medicaid. Your election change must correspond with the gain or loss of coverage.

8. Your dependent care expenses change due to a provider rate change. This includes both increases and decreases in expenditures. However, you may only make a change if the provider is not your relative.

9. Change in dependent care providers. You may make an election change to reflect the cost of the new provider. It is also considered a provider change and election decreases are allowed when your child is no longer eligible for childcare or is only in after-school care due to entering kindergarten or first grade.

A change in election is allowable and consistent with IRS regulations only if the change in status results in the employee, or their spouse or dependent, gaining or losing eligibility for health coverage under either the cafeteria plan or health plan of the employee or the employer of their

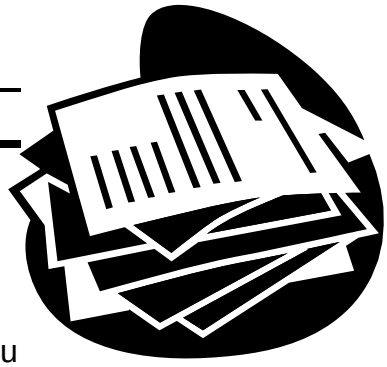
spouse or dependent and the election change corresponds with that gain or loss of coverage.

If the change in status event is the birth of a child, and the employee is a participant in the Plan at the time of birth, the effective date of coverage is the date of birth. If the change in status event is for reasons other than the birth of a child and the employee is a participant in the Plan, the effective date of coverage is the first appropriate pay period following the receipt of the election form.

If an employee is not enrolled in the Plan prior to the change in status event, the effective date of coverage is the date the first payroll contribution is received.

Form (SFN 53511) FlexComp Change in Status must be completed and submitted to NDPERS along with the FlexComp Enrollment (SFN 53851) form within 60 days of the change in status event. Forms are available from your human resource/payroll office or on our web site at www.discovernd.com/ndpers.

TERMINATION OF EMPLOYMENT



CONTINUATION OF COVERAGE IN A MEDICAL SPENDING REIMBURSEMENT ACCOUNT (COBRA)

If you retire or terminate employment during the Plan Year, you will be offered COBRA continuation coverage through the end of the Plan Year. You will have sixty (60) days from the date the notice of your right to continue coverage is provided to you to elect continuation coverage. Unless you select COBRA, your coverage will end on the last day of the month in which you terminate your employment.

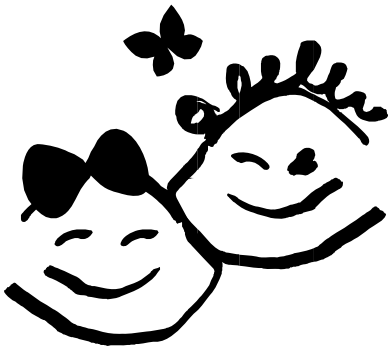
If participation terminated due to a separation of service and you return to state employment within 30 days in the same Plan Year, your election will be reinstated as it was immediately prior to the separation of service.

If you return to state employment after 30 days in the same Plan Year, you may not participate in the Plan for the remainder of the year. You may file claims for qualifying expenses and be reimbursed from your Medical Spending account for services received while you were a participant in the Plan. Your participation in the Dependent Care Reimbursement account will continue through the end of the plan year or until you have been reimbursed the balance in your account.

If you become widowed, divorced, or legally separated or your dependent child ceases to be a dependent under the terms of the Plan, your spouse or dependent(s) may have the right to continuation coverage. It is the responsibility of the person seeking continuation coverage to inform NDPERS within 60 days of the occurrence of the event.

The remaining program contribution payments will be charged to you, your spouse, or your dependent, as the case may be, in equal payments through the end of the Plan Year at 102%. Any program contribution payment amount in excess of 100% of the cost of providing coverage shall not be credited to the participant's account but shall be treated as an administrative charge.

If continuation coverage is elected, coverage will be extended to the end of the current Plan Year but may terminate sooner if the premiums described above are not paid within 30 days of their due date which is the 1st of every month.



DEPENDENT CARE REIMBURSEMENT ACCOUNT
(No COBRA Continuation Coverage Offered)

If you terminate employment your contributions will cease and payroll deductions will stop after the last day of the month in which you terminate. You may continue to file claims for qualifying expenses incurred during the Plan Year until you have been reimbursed the remaining balance in your account, if any.

The final day for accepting claims for the Plan Year from either your Medical Spending or Dependent Care Reimbursement account for services received while you were a participant is three months after the Plan Year ends on December 31 or until March 31.

FREQUENTLY ASKED QUESTIONS

Q. What if I already participate? Do I have to re-enroll?

A. Participation in all three pre-tax accounts (Premium Conversion, Medical Spending, and Dependent Care Accounts) terminates at the end of each Plan Year. You must re-enroll each year during the annual open enrollment to continue your participation with the exception of the first $50,000 of ING employee supplemental life insurance. We will automatically pre-tax your premium deduction up to the first $50,000 of employee supplemental coverage unless you make an election to decline this action.

Q. If my spouse and I both work for the State of North Dakota, can we both enroll?

A. Yes, both of you will be allowed to enroll in the Plan. If both you and your spouse decide to enroll, each of you will have your own account and payroll deduction. Each of you will need to determine your own annual maximum up to $6,000 for medical spending reimbursement. You cannot submit a claim that your spouse has already filed and been reimbursed for, so careful planning and claim monitoring is important. Even though you may both enroll in the Dependent Care account, you are limited to an annual family maximum of $5,000.

Q. Can I change my election during the year if unexpected medical expenses arise after the start of the plan year?

A. The IRS requires that once you elect to participate, your payroll deductions may not be stopped or changed until the start of the next plan year. The only exception is if you experience an IRS Qualified Change of Status. Unexpected medical expenses for whatever reason do not allow an employee to change their election to increase or decrease their medical spending amount.

Q. What happens to my remaining Medical Spending and Dependent Care Account unclaimed balances if I accept another state job, terminate my employment or retire during the Plan Year?

A. See Termination of Employment.

Q. Will I be kept current regarding the status of my account(s)?

A. NDPERS will keep you informed about your account balances by providing you with quarterly statements throughout the plan year to let you know how much money you have used and what you have left in your account(s).

Q. When will I receive payments from my account(s)?

A. During the course of the Plan Year you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is provided, not when it is paid for. However, expenses must be submitted no later than 3 months following the end of the Plan Year on December 31. The final day for accepting claims for the Plan Year is March 31.

Q. What documentation do I need to provide the Plan Administrator to be reimbursed for expenses I incur?

A. You must complete and sign a FlexComp Reimbursement Voucher (SFN 16868), attach the required documentation, and return it to NDPERS. The acceptable forms of documentation to submit along with the completed claim form are listed on the back of the form. Forms are available from your human resource/payroll office or on our web site at www.discovernd.com/ndpers.

Q. Are photocopies of the insurance Explanation of Benefits (EOB), itemized statements, etc. acceptable?

A. Yes. To avoid claims processing delays, DO NOT use staples or highlighters on your form or receipts, copy on 8 ½ X 11 inch size paper, single sheets only, use only blue or black ink for completing your form.

ELIGIBLE EXPENSES FOR REIMBURSEMENT FROM A MEDICAL SPENDING ACCOUNT

A medical spending account can be used to reimburse medical expenses that qualify under Internal Revenue Code Section 213, excluding all insurance premiums and long term care expenses. “Medical care” expenses as defined by Section 213 include amounts paid for the diagnosis, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expense must be to alleviate or prevent a physical defect or illness. Only the portion of the expense you owe after insurance has paid can be claimed.

The following is a partial list of some eligible expenses and should be used as a guide. Prior to receiving service, please contact the NDPERS FlexComp Coordinator for information and assistance on any items not clearly identified as qualifying or not qualifying.

Acupuncture. Medical expenses paid for acupuncture are reimbursable.

Alcoholism and drug abuse. Inpatient medical expenses paid to a treatment center for alcohol or drug abuse are reimbursable.

Ambulance. Medical expenses paid for ambulance service are reimbursable.

Artificial limb. Medical expenses paid for an artificial limb are reimbursable.

Birth control pills and devices. Medical expenses paid for birth control pills and devices prescribed by a doctor are reimbursable.

Braille books and magazines. The amount by which the cost exceeds the price for regular books and magazines is reimbursable.

Exercise Programs. Payments made on a per-treatment basis may be an eligible expense if treatment has been prescribed by your physician to treat a specific medical condition or injury. A letter from your physician certifying the specific medical condition or injury is required along with the number of treatments being prescribed. (For example, treatments are being prescribed three times a week for three months).

Fertility. Medical expenses related to the treatment of infertility, including in vitro fertilization, (including storage of sperm or eggs) and surgery (including an operation reversing sterilization surgery) are reimbursable.

Guide dog. The cost of a guide dog used by the visually impaired or hearing impaired is reimbursable.

Hearing aids. Medical expenses for a hearing aid and batteries are reimbursable.

Lodging. The cost of lodging not provided in a hospital or similar institution while away from home to receive medical care is reimbursable if lodging is primarily for and essential to medical care. The medical care must be provided by a doctor in a hospital or medical care facility; the lodging should not be lavish or extravagant; and there should be no significant element of personal pleasure, recreation, or vacation in the travel away from home. Lodging is included for the person that is traveling with the person receiving the medical care. The reimbursable amount cannot exceed $50 per night for each person. Meals incurred in route to a place of medical treatment are not reimbursable.

Massage Therapy. The cost to receive massage therapy may be eligible if prescribed by your physician to treat a specific medical condition or injury. A letter from your physician certifying the specific medical condition or injury is required along with the number of treatments being prescribed. (For example, treatments are being prescribed once a week for three months).

Psychiatric care, Psychoanalysis, Psychologist. Expenses for psychiatric care, psychoanalysis, or psychological care are reimbursable.

Smoking cessation program. The cost of a stop smoking program and stop-smoking drugs are reimbursable.

Transportation, tolls, and parking. Amounts paid for transportation to another location, if the trip is primarily for and essential to receiving medical care, are reimbursable. The mileage rate for traveling by car to obtain medical care is 15 cents per mile.

Vasectomy. Medical expenses related to a vasectomy are reimbursable.

Weight Loss Programs to Treat Obesity. The cost to join a weight loss program and attend periodic meetings may be eligible. A letter from your physician certifying the specific medical condition including the diagnoses of obesity is required. The cost for these services can only be reimbursed as the services are received. Pre-payment of services can not be reimbursed when the payment is made. The cost of special food purchased as part of a weight loss program is not eligible.

Wheelchair. The cost of a wheelchair used for the relief of sickness or disability is reimbursable. The cost of operating and maintaining the wheelchair is also reimbursable.

OVER-THE-COUNTER DRUGS
Reimbursement Guide

Reimbursable Items

Allergy Medicines
Antacids
Antidireals
BenGay/Tiger Balm (for muscle pain)
Cold Medicines
Cough drops
Denture adhesives
Eye drops
Former prescription-only drugs
Laxatives
Menstrual cycle medicines
Motion sickness pills
Ointment or cream (for sunburn)
Pain Relievers
Pedialyte
Sinus medications/sinus sprays
Sleeping aides (occasional insomnia)
Smoking Cessation Items
Suppositories (hemorrhoids)
Throat lozenges
Topical creams & first aide creams (Bactine, diaper rash ointment, calamine, bug bite medicines, wart removers, cold sore medicine)

Non-Reimbursable Items

Cosmetics
Facial Creams
Moisturizers
One-a-day basic multiple vitamins
Suntan lotion, except for skin cancer